Pathways to a sustainable and effective primary health care nursing workforce

APNA 2013 Federal Budget Submission

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Summary

The nursing workforce is the backbone of the healthcare system. Ensuring an adequate, well-trained and well supported nursing workforce is key to meeting the rapidly increasing healthcare needs of an ageing Australian population with an increasing burden of chronic disease.

A great deal of this burden of disease will need to be dealt with at primary care level, and nurses are a critical component of the general practice and primary health care workforce.

APNA's proposals aim to improve health outcomes for Australians by ensuring the primary health care nursing workforce has a sustainable capacity, and is engaged, prepared and supported to meet the health needs of the community.

APNA proposes three measures for consideration in the 2013 Federal Budget:

1 **Funding to APNA to lead the development of an education and career framework for nurses in primary health care, particularly those working in general practice.**

2 **A targeted increase in Practice Nurse Incentive Program (PNIP) funding to encourage the engagement of primary health care professionals in aged care.**

3 **An integrated cardiovascular health assessment program to be implemented through general practice and other primary health care settings.**

Required investment:

MEASURE	BUDGET 2013-14	FORWARD ESTIMATE	TOTAL
1 Education and Career Framework	$1M	$1M in 2014-15	$2M
2 Aged care incentive	$8.4M	$8.4M annually	$8.4M annually
3 CVD health assessment program	$TBC	$TBC	$TBC

1. Development of an education and career framework for primary health care nurses

Background

The majority of general practices in Australia employ at least one practice nurse, and the number of practice nurses is increasing substantially every year. In addition, nurses make an important contribution across a number of other primary health care settings, such as community health services, schools, workplace health and safety services, and so on. Yet there are major risks to the capacity of this workforce going forward.

Health Workforce Australia's report *Health Workforce 2025* predicts a shortage of almost 110,000 nurses in Australia by 2025, and identifies this as a critical risk for the Australian healthcare system. The report also notes that this predicted shortfall cannot be addressed through training and recruitment alone, but that retention and productivity measures will also be necessary if we are to inhibit a nursing workforce crisis.

The nursing shortage will without doubt impact on general practice and primary health care. Already, more than four in five nurses working in general practice are aged over 40, with the largest cohort being in their fifties. Yet there are currently no formal pathways through nurse education and training into general practice and primary health care; no career structure for nurses working in general practice and primary health care; and no national workforce plan for general practice nursing.

Such a plan would deal with current problems including the lack of supported clinical placements in primary care in the context of bottlenecks for new nursing graduates seeking placements; the barriers to re-entry for trained nurses who have been out of the workforce for a period; and the high level of exits from primary care nursing due to the lack of career development opportunities.

Nurses are a substantial component of the primary health care workforce, and make an increasingly important contribution to primary health care in Australia. Primary health care nurses play a major role in improving health outcomes through their role in delivering quality chronic disease management, immunisation services, and other preventative care, as well as curative care and improvements in primary health care systems.

Resolving these priority areas will enable the vital work of a primary health care nurse workforce within the broader primary health care reform agenda, ensuring high quality of care, and the success of key initiatives including the embedding of ehealth, and the development of the patient-centred medical home.

Despite this, there is no national plan for the primary health care nursing workforce.

There is a critical need for a plan to improve recruitment, retention and productivity in the primary health care nursing workforce. Such a plan relies on defined educational pathways into primary health care nursing, and a defined career structure with related training and scope of practice, to enable nurses to develop within the profession and contribute to their optimal level.

Proposal

APNA proposes developing an education and career framework for nurses working in the primary care sector, particularly general practice settings. This pathway would:

- Include a formal system to support undergraduate and postgraduate clinical placements in primary health care settings, to encourage recruitment into the sector.

- Establish a career structure which ensures nurses working in primary health care can increase their education and training, skills, and scope of practice throughout their careers, supporting retention and productivity.

A comprehensive career framework for practice nurses has been developed and implemented in the UK over the past few years, with significant benefits accruing in a range of areas:

- Improved quality of care
- Improved retention of general practice nurses
- Increased productivity, with all members of the primary health care team able to work at the top of their scope of practice.

The learnings from the UK experience will be used as a starting point for the Australian project. The development of an education and career framework and accompanying resources – including toolkits covering competency standards, protocols for assessment of competencies, role descriptions, etc – requires resourcing for significant research and consultation; and the proposed timeframe of two years from commencement to completion is based on the UK experience.

The proposed investment is $1 million for each of the next two financial years. The long term savings to the healthcare system will greatly exceed this initial outlay.

COST: $1M annually over two years (2013-14 and 2014-15)

TOTAL INVESTMENT	**$2M**

2. Enhancing continuity of care for people in residential aged care facilities through primary health care engagement

Background

People in residential aged care facilities (RACFs) are particularly vulnerable, and make consistently high demands on the healthcare system. Greater engagement of primary health care professionals with residential aged care can help to manage these demands, reduce hospitalisation, and improve quality of care and quality of life for residents.

Data from the period 2008-2010 suggest that approximately 200,000 people received permanent residential aged care in a single year (equivalent to 10.5% of people aged 70 years or over). The average length of stay as a permanent resident was almost three years, with nearly one in five residents being in care for five years or more. Fifty-nine per cent of all residents had a dementia diagnosis.

Levels of hospitalisation pending admission to residential care were high: 16.3% of people aged 70 or over (Indigenous people aged 50 years and over) remained in hospital for 35 days or longer 'awaiting admission to residential care'. Re-hospitalisations were also high: about a third of residential aged care facility patients discharged from the acute sector are re-admitted within two weeks. About 80% of those re-admissions are due to medication errors.

Primary care engagement with residential aged care is very low. Fewer than 20% of Australian GPs attend RACFs at all, and only 6% of GPs attend RACFs regularly. Younger GPs are less engaged with RACFs than older GPs: the average age of a GP who regularly attends RACFs is around 57 years. This suggests even lower levels of engagement in the future. There is also limited continuity of care: over 90% of patients admitted to a RACF are admitted under the care of a GP who already attends the RACF but has never encountered that patient before.

There are several reasons for this low general practice engagement with RACFs. RACF residents are associated with higher workload for GPs than other patients of the same age and gender living in the community. In addition, it is common for RACFs to employ a large proportion of casual or agency staff, which impacts on the capacity to build up cooperative relationships. Eighty-four per cent of GPs reported that they were sometimes called out unnecessarily, citing lack of knowledge due to staff turnover, and use of agency staff as two of the reasons for this. GPs also felt that as a result of the higher turnover of RACF staff, they often worked with nurses who were inexperienced, under-skilled and unfamiliar with the patients, impacting on communication and quality of care.

In summary, there is a substantial workforce problem for general practitioners providing care to people in residential aged care facilities; and continuity of care is often problematic to achieve, leading to inconsistency and preventable variation in care.

Proposal

This proposal seeks to build on the existing mechanisms within the Medicare Benefits Schedule (MBS) that aim to provide high quality care to people living in residential aged care facilities. It seeks to enhance the participation of primary health care providers in the RACF setting; and particularly to enhance continuity of multidisciplinary care provided from a general practice to a resident.

It seeks to provide flexibility to general practices, such that the care for people can be tailored to the needs of the residents in aged care facilities – allowing for a practice nurse to attend the RACF if that is appropriate, or to provide services at the general practice that allow the GP to attend the RACF for an extended period not covered by the MBS (e.g. to consult with RACF staff about patient care) where that is appropriate. It seeks to build on previous successful models of quality incentives by supporting a number of different aspects of the context simultaneously.

APNA recommends:

1. An enhancement of the Practice Nurse Incentive Program (PNIP), whereby practices attract an additional $10 payment per patient when they meet the following criteria:
    - A patient claims a rebate for a comprehensive medical assessment (CMA) for a service by a GP at the practice
    - The same patient claims a rebate for a professional attendance by a GP at the same practice 3 months after the claim for the CMA, indicating continuity of care by the practice.

    COST: $2M annually

2. Establishment of a RNIP (Registered Nurse Incentive Payment) whereby RACFs are paid an additional $10 when they meet the following criteria:
    - A patient claims a rebate for a comprehensive medical assessment for a service by a GP at the practice
    - The same patient claims a rebate for a professional attendance by a GP at the same practice 3 months after the claim for the CMA, indicating continuity of care by the practice.

    COST: $2M annually

3. A $10,000 'flagfall'/'one-off' ehealth incentive payment to each RACF, paid when the RACF demonstrates that it has the capability of providing secure real-time access for general practitioners and staff employed by their practice to the health record held by the general practice for residents in the facility. **COST: $1M annually**

4. A $70,000 annual payment to Medicare Locals in locations where more than 15% of the people in the catchment are 70 years or over (or are Indigenous Australians who are 50 years or over) dedicated to the employment of an advanced practice nurse or nurse practitioner with specific skills in the care of older people in residential facilities. **COST: $1.4M annually**

5. An enhancement of the PNIP, whereby practices attract an additional payment of $10,000 when they meet the following criteria:
    - The practice's proportion of patients who are readmitted to a hospital within two weeks of discharge is 5% lower than the national average. **COST: $1M annually**

6. An enhancement of the Registered Nurse Incentive Payment, whereby RACFs attract an additional payment of $10,000 when they meet the following criteria:
    - The practice's proportion of patients who are readmitted to a hospital within two weeks of discharge is 5% lower than the national average. **COST: $1M annually**

TOTAL INVESTMENT	**$8.4M annually**

3. An integrated cardiovascular health assessment program in primary health care

Background

Cardiovascular disease (CVD) is Australia's biggest killer, causing more than 46,000 deaths each year – just over a third of total mortality – and afflicting 3.5 million adults.[1] It accounts for 16% of the overall burden of death and disease in Australia and is the most expensive disease group in terms of direct healthcare costs, at $6 billion a year or 11% of recurrent expenditure.[2]

CVD has a strong relationship with type 2 diabetes and chronic kidney disease. Because they share risk factors, underlying causes and disease mechanisms, stroke, heart and vascular diseases often occur together with diabetes and chronic kidney disease. For example, it is estimated over 400,000 Australians have both CVD and diabetes. Thus, effective prevention and management of one condition can lead to reduction in the risk of related diseases.[3]

Modifiable risk factors for CVD and related diseases include tobacco smoking, high blood pressure, high blood cholesterol, insufficient physical activity, overweight and obesity, poor nutrition and type 2 diabetes. Atrial fibrillation (irregular heartbeat), transient ischaemic attack and a high intake of alcohol also increase the risk of stroke.[4]

Recent data shows while some risk factors such as smoking and alcohol consumption are coming down in Australia there are other risk factors not being managed well, particularly overweight and obesity, and hypertension.

A coordinated approach is required to increase awareness of individual vascular and related disease risk, to provide high quality assessment of individual risk and to provide appropriate interventions to support risk management.

Identification of risk and action to modify these risk factors has significant potential to reduce the number of CVD events occurring each year and reduce incidence of diabetes and chronic kidney disease. However current Australian Government funded health checks are not identifying those at risk primarily because of low access rates, non-integrated approaches to CVD risk assessment and the absence of a national program to support better management of risks for CVD and related diseases like type 2 diabetes and kidney disease. Less than a quarter of those over 75 years and only 6% of those aged 45-49 are accessing regular health checks.[5] Given the proportion of overweight, obese and hypertensive people in the community these figures are alarming.

[1] Australian Institute of Health and Welfare, Australia's health 2010. 2010, AIHW.
[2] Australian Institute of Health and Welfare, Australia's health 2010. 2010, AIHW.
[3] Australian Institute of Health and Welfare, Prevention of cardiovascular disease, diabetes and chronic kidney disease: targeting risk factors. Cat. no. PHE 118. 2009, AIHW: Canberra
[4] Australian Institute of Health and Welfare, Australia's health 2010. 2010, AIHW.
[5] AIHW 2009 – data summarised in National Vascular Disease Prevention Alliance Position Paper, May 2011, Risk awareness raising, assessment and management for the prevention of vascular and related diseases.

Proposal

APNA supports the call (led by the Heart Foundation and Stroke Foundation) for the Australian Government to fund an integrated heath assessment program linking assessment, prevention, coordinated care and management which encompasses the following elements:

1. **Assessment** of risk factors, including kidney function, diabetes status, using AusDrisk, or blood glucose testing in high-risk individuals, and the calculation of an absolute risk score assessment for stroke and heart attack risk.
2. **Prevention** for those at high risk of type 2 diabetes or with high absolute cardiovascular risk or high kidney risk. Those identified at high risk of chronic disease in the assessment phase are referred to appropriate community-based lifestyle modification programs.

   It is proposed that Chronic Disease Care Coordinators are established to assist with care coordination and provision of self-management support. There is good evidence that this coordination role has a positive impact on patient outcomes and is best performed by a non-GP care coordinator and leads to a significantly lower use of health services.[6]

   In APNA's view, primary health care nurses are best placed to take on the role of chronic disease care coordinators and in many cases already hold this role either formally or informally.

   To enhance the capacity of the Chronic Disease Care Coordinators to deliver the range of activities required, a Primary Health Care Provider Network should be established to support Chronic Disease Care Coordinators and other primary health care providers to promote interdisciplinary communication, networking and collaborative practice.
3. Pharmacotherapy and lifestyle advice are among the **management and treatment** tools for those at high risk of developing cardiovascular and related diseases.

Comprehensive vascular and related disease risk assessments and the delivery of ongoing preventative care for those people identified to be at higher risk can be undertaken effectively in the primary health care setting, with the involvement of the primary health care team, led by general practitioners and primary health care nurses.

Assessment and classification of moderate and high-risk individuals will result in provision of medical interventions to reduce individual risk, and referral to quality-assured lifestyle modification programs. Medical interventions may include drug treatments for high blood pressure and high blood cholesterol. Evidence-based lifestyle interventions may include smoking cessation services, weight management, or exercise and behaviour change programs.

This process will have potentially significant benefits to those at risk as well as to the healthcare system. The direct health cost of cardiovascular diseases (about $7.9B a year) could be contained with early identification and management of those at high risk before they develop these chronic diseases, particularly for those aged over 45.

Anticipated benefits include systemic efficiencies, substantial cost savings and reduction in chronic disease related hospitalisations. In addition, the proposal supports a number of priority areas within the National Primary Health Care Strategy 2010.

[6] Productivity Commission, 2005, Australia's Health Workforce: Productivity Commission research report, Canberra: Commonwealth of Australia.

About APNA

APNA's Vision is for a healthy Australia through best practice primary health care nursing.

APNA is the peak professional body for nurses working in primary health care including general practice. With more than 3000 members, APNA provides primary health care nurses with a voice, access to quality continuing professional development, educational resources, support and networking opportunities. APNA continually strives to increase awareness of the role of the primary health care nurse, and to be a dynamic and vibrant organisation for its members.

Primary health care nursing is wide ranging and covers many specialist areas including general practice, Aboriginal health, aged care, occupational health and safety, telephone triage, palliative care, sexual health, drug and alcohol issues, women's health, men's health, infection control, chronic disease management, cardiovascular care, immunisation, cancer, asthma, COPD, mental health, maternal and child health, health promotion, care plans, population health, diabetes, wound management and much more.

APNA aims to:

1. Support the professional interests of primary health care nurses
2. Promote recognition of primary health care nursing as a specialised area
3. Provide professional development for primary health care nurses
4. Represent and advocate for the profession
5. Collaborate with other stakeholders to advance our mission
6. Ensure a sustainable and growing professional association, by and for primary health care nurses.